



**BlueCross BlueShield
of North Carolina**

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BlueOptionsSM

City of Durham

Premium PPO Plan

Effective Date 09/01/2011

Benefit Highlights



Blue OptionsSM Benefit Highlights (PPO)

Physician Office Services (See "Outpatient Hospital Services" for "outpatient clinic" or "hospital-based" services.)	In-network	Out-of-network ¹
Office Visit		
<i>Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity in and out of network.</i>		
Primary Care Provider	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
Preventive Care		
<i>Routine Examinations, Well-Child Care, Immunizations, Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs).</i>		
Primary Care Provider	100%	Not Available*
Specialist	100%	Not Available*
Outpatient Clinic	100%	Not Available*
<i>*Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs) are covered Out-of-network.</i>		
Therapies		
<i>Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$15 copayment	\$15 copayment
Emergency Room Visit (<i>Inpatient Hospital benefits apply if admitted. If held for Observation, Outpatient benefits apply. See "Inpatient and Outpatient Hospital Services"</i>)	\$300 copayment	\$300 copayment
Ambulatory Surgical Center	90% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	90% after deductible	70% after deductible
Outpatient Clinic Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services	90% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEG's and EKG's	90% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	90% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (<i>60 days per Benefit Period</i>)	90% after deductible	70% after deductible
Home Health Care, Ambulance,	90% after deductible	70% after deductible
Durable Medical Equipment and Hospice		
Maternity		
<i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (Delivery)	90% after deductible	70% after deductible
Professional Services (Delivery)	90% after deductible	70% after deductible
Transplants		
Hospital Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible

Blue OptionsSM Benefit Highlights (PPO)

Infertility Services

Up to \$5,000

Primary Care Provider	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
Hospital Services	90% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	90% after deductible	70% after deductible
Vision (Comprehensive Eye Exam)	100%	Not Available

Lifetime Maximum, Deductibles & Coinsurance Maximums

The following Deductibles and Coinsurance Maximums apply to the services on the previous page [and Mental Health and Substance Abuse services below]:

	In-network	Out-of-network ¹
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual (per Benefit Period)	\$500	\$1000
Family (per Benefit Period)	\$1000	\$2000
Coinsurance Maximum		
Individual (per Benefit Period)	\$1500	\$3000
Family (per Benefit Period)	\$3000	\$6000

Mental Health and Substance Abuse Services

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.

Mental Health Services

	Certified*	Non-Certified ¹
Office visits	\$30 copayment	70% after deductible
Inpatient Hospital	90% after deductible	70% after deductible
Outpatient Hospital	90% after deductible	70% after deductible

Substance Abuse Services

Office Visit	\$30 copayment	70% after deductible
Inpatient Hospital	90% after deductible	70% after deductible
Outpatient Hospital	90% after deductible	70% after deductible

Prescription Drugs- Retail Pharmacy

Up to 31 day supply. 32-90 day supply is two copayments. Infertility Drugs up to \$5000. MAC B Pricing, Brand Penalty.

Tier 1 (Generic)	\$0 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$20 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$35 copayment	Copayment + charge over In-network allowed amount
Diabetic Supplies:	100%	100%
Spacers and Peak Flow Meters:	100%	100%

Medco Mail Order - 90 day supply:

Tier 1 (Generic)	\$0 copayment	Not Available
Tier 2 (Preferred Brand)	\$40 Copayment	Not Available
Tier 3 (Brand)	\$70 copayment	Not Available
Diabetic Supplies	100%	Not Available
Spacers and Peak Flow Meters	100%	Not Available

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount

The charge that BCBSNC determines using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

Coinsurance Maximum

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services. NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

Day and Visit Maximums

All day and visit maximums are on a combined In- and Out-of-Network basis.

Utilization Management

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review and care management.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

Certification

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and certain outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility.

Health and Wellness Program

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What Is Not Covered?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.



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BlueOptionsSM

City of Durham

Core PPO Plan

Effective Date 09/01/2011

Benefit Highlights



Blue OptionsSM Benefit Highlights (PPO)

	In-network	Out-of-network ¹
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Office Visit		
<i>Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity in and out of network.</i>		
Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Preventive Care		
<i>Routine Examinations, Well-Child Care, Immunizations, Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs).</i>		
Primary Care Provider	100%	Not Available*
Specialist	100%	Not Available*
Outpatient Clinic	100%	Not Available*
<i>*Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs) are covered Out-of-network.</i>		
Therapies		
<i>Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$20 copayment	\$20 copayment
Emergency Room Visit (<i>Inpatient Hospital benefits apply if admitted. If held for Observation, Outpatient benefits apply. See "Inpatient and Outpatient Hospital Services"</i>)	\$300 copayment	\$300 copayment
Ambulatory Surgical Center	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Outpatient Clinic Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEG's and EKG's	80% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (<i>60 days per Benefit Period</i>)	80% after deductible	70% after deductible
Home Health Care, Ambulance,	80% after deductible	70% after deductible
Durable Medical Equipment and Hospice		
Maternity		
<i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (Delivery)	80% after deductible	70% after deductible
Professional Services (Delivery)	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

Blue OptionsSM Benefit Highlights (PPO)

Infertility Services

Up to \$5,000

Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible

Vision (Comprehensive Eye Exam)	100%	Not Available
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Lifetime Maximum, Deductibles & Coinsurance Maximums

The following Deductibles and Coinsurance Maximums apply to the services on the previous page [and Mental Health and Substance Abuse services below]:

	In-network	Out-of-network ¹
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual (per Benefit Period)	\$750	\$1500
Family (per Benefit Period)	\$1500	\$3000
Coinsurance Maximum		
Individual (per Benefit Period)	\$2000	\$4000
Family (per Benefit Period)	\$4000	\$8000

Mental Health and Substance Abuse Services

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.

Mental Health Services

	Certified*	Non-Certified ¹
Office Visits	\$40 copayment	70% after deductible
Inpatient Hospital	80% after deductible	70% after deductible
Outpatient Hospital	80% after deductible	70% after deductible

Substance Abuse Services

Office Visit	\$40 copayment	70% after deductible
Inpatient Hospital	80% after deductible	70% after deductible
Outpatient Hospital	80% after deductible	70% after deductible

Prescription Drugs

Up to 31 day supply. 32-90 day supply is two copayments. Infertility Drugs up to \$5000. MAC B Pricing, Brand Penalty.

Tier 1 (Generic)	\$0 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$30 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$45 copayment	Copayment + charge over In-network allowed amount
Diabetic Supplies	100%	100%
Spacers and Peak Flow Meters	100%	100%

Medco Mail Order - 90 day supply:

Tier 1 (Generic)	\$0 copayment	Not Available
Tier 2 (Preferred Brand)	\$60 Copayment	Not Available
Tier 3 (Brand)	\$90 copayment	Not Available
Diabetic Supplies	100%	Not Available
Spacers and Peak Flow Meters	100%	Not Available

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period

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Allowed Amount

The charge that BCBSNC determines using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

Coinsurance Maximum

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services. NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

Day and Visit Maximums

All day and visit maximums are on a combined In- and Out-of-Network basis.

Utilization Management

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review and care management.

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Certification

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What Is Not Covered?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

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- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.



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BlueOptionsSM

City of Durham

Basic PPO Plan

Effective Date 09/01/2011

Benefit Highlights



Blue OptionsSM Benefit Highlights (PPO)

Physician Office Services (See "Outpatient Hospital Services" for "outpatient clinic" or "hospital-based" services.)	In-network	Out-of-network ¹
Office Visit		
<i>Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity in and out of network.</i>		
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Preventive Care		
<i>Routine Examinations, Well-Child Care, Immunizations, Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs).</i>		
Primary Care Provider	100%	Not Available*
Specialist	100%	Not Available*
Outpatient Clinic	100%	Not Available*
<i>*Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs) are covered Out-of-network.</i>		
Therapies		
<i>Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$25 copayment	\$25 copayment
Emergency Room Visit (<i>Inpatient Hospital benefits apply if admitted. If held for Observation, Outpatient benefits apply. See "Inpatient and Outpatient Hospital Services"</i>)	\$300 copayment	\$300 copayment
Ambulatory Surgical Center	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Outpatient Clinic Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEG's and EKG's	80% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (<i>60 days per Benefit Period</i>)	80% after deductible	70% after deductible
Home Health Care, Ambulance,	80% after deductible	70% after deductible
Durable Medical Equipment and Hospice		
Maternity		
<i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (Delivery)	80% after deductible	70% after deductible
Professional Services (Delivery)	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

Blue OptionsSM Benefit Highlights (PPO)

Infertility Services

Up to \$5,000

Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible

Vision (Comprehensive Eye Exam)

100%

Not Available

Lifetime Maximum, Deductibles & Coinsurance Maximums

In-network

Out-of-network¹

The following Deductibles and Coinsurance Maximums apply to the services on the previous page and Mental Health and Substance Abuse services below:

Lifetime Benefit Maximum

Unlimited

Unlimited

Deductibles

Individual (per Benefit Period)	\$1,500	\$3,000
Family (per Benefit Period)	\$3,000	\$6,000

Coinsurance Maximum

Individual (per Benefit Period)	\$3,000	\$6,000
Family (per Benefit Period)	\$6,000	\$9,000

Mental Health and Substance Abuse Services

Certified*

Non-Certified¹

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Mental Health Services

Office Visits	\$50 copayment	70% after deductible
Inpatient Hospital	80% after deductible	70% after deductible
Outpatient Hospital	80% after deductible	70% after deductible

Substance Abuse Services

Office Visit	\$50 copayment	70% after deductible
Inpatient Hospital	80% after deductible	70% after deductible
Outpatient Hospital	80% after deductible	70% after deductible

Prescription Drugs

Up to 31 day supply. 32-90 day supply is two copayments. Infertility Drugs up to \$5000. MAC B Pricing, Brand Penalty.

Tier 1 (Generic)	\$0 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$35 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$50 copayment	Copayment + charge over In-network allowed amount
Diabetic Supplies	100%	100%
Spacers and Peak Flow Meters	100%	100%

Medco Mail Order - 90 day supply:

Tier 1 (Generic)	\$0 copayment	Not Available
Tier 2 (Preferred Brand)	\$70 Copayment	Not Available
Tier 3 (Brand)	\$100 copayment	Not Available
Diabetic Supplies	100%	Not Available
Spacers and Peak Flow Meters	100%	Not Available

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